NEW PATIENT INFORMATION

First Name: (*Print Below*)	**Middle Name:**	**Last Name:**

Address:

City:	**State:**	**Zip:**
Date of Birth:	**Soc. Sec. #**	**Sex:**

<u>Check All That Apply</u>: [ ] Single [ ] Married [ ] Other

[ ] Employed [ ] Student F/T [ ]Student P/T [ ]Other

Employer or School:

City of Employment:	**Job Title:**	
Home #	**Office/School #**	**Ext:**
Mobile #	**Emergency Contact #**	**Name/Relation**
Treating Psychiatrist	**Psychiatrist #**	
Primary Care Provider	**Primary Care Provider #**	

Email Address **Referred By:**

PRIMARY INSURED'S INFORMATION ***Mark box if same as above***

First Name: (*Print Below*) **Middle Name:** **Last Name:**

Address:

City: **State:** **Zip:**

Date of Birth: **Soc. Sec. #** **Sex:**

Patient's Relationship: **[ ] Self** **[ ] Spouse** **[ ] Parent**
[ ] Child **[ ] Other (*Specify Below*)**

Employer or School:

City of Employment/School: **Job Title:**

Home # **Office/School #** **Ext:**

Mobile # **Email**

Insurance Plan Name (*i.e. Aetna*)

Member ID #	Group ID #

Assignment of Benefits & Release of Information

I hereby assign, transfer and set over to Provider, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine, maintain, or audit insurance benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company, or of any balance due after payments by my Insurance Company.

___________________________ _______________________

Parent/Guardian/Patient Signature Date

PAYMENT INFORMATION		
Credit Card #	**Expiration Date**	**3 Digit CVV (*On Back*)**
Name (*As it Appears on Card*)	**Zip Code:**	**( ) Check for appointment reminders**

Financial Policy

I, ____, the undersigned, have requested services from David Tolbert, MA, LMHC. I agree to pay for services at the following rates and to abide by the terms outlined in this contract and the attached new patient package.

Individual Therapy 50-60 min. $100.00

Couples/Family Therapy 50-60 min. $110.00

Couples/Family Therapy 80-90 min $150.00

Weekend/Evening Appt 50-60 min. $180.00

Telephone Consult 0-15 min $ 35.00

Report Preparation 0-15 min $ 35.00

Court Appearance 50 min. $300.00

It is the nature of a counseling practice to dedicate an entire fifty to sixty minute session for each client - you. Your therapist has a full practice and often has a waiting list of new clients and existing clients in need of an appointment time. For this reason, it is very important that if you need to reschedule or cancel an appointment you give the therapist forty- eight (48) hours notice so another client can be scheduled in your place. Cancelling an appointment with less than 48 hours notice will be considered a “late cancel.” Insurance companies do NOT pay for “late cancel” or “no show” appointments. Therefore it is your responsibility to pay the full appointment fee for each appointment that is held for you and is a “late cancel” or a “no show.” These “late cancel” or “no show” appointments are very costly to a practice where only one client or one family is seen per hour – in addition, services are not given to others who are in need of the appointment.

Many therapists have this policy, however, there continues to be a difficulty in collecting this cancellation fee. For this reason, it is this office’s policy to require a valid credit card number or a cash deposit of $95.00 to hold appointments. If you “late cancel” or “no show” for an appointment your credit card will automatically be deducted the full appointment fee or your $95.00 cash deposit will be depleted and a new deposit will be required to schedule another appointment. By signing below you specifically authorized the credit card payment in accordance with this policy. Our goals are common. Your treatment is my number one priority and my hope is that you will be able to attend each appointment scheduled or re-schedule appointments allowing more than 48 hours notice. It is important for both the therapist and the client to have mutual respect for each other’s time. Just as you expect to get paid for the time you are at work so does your therapist. By cancelling with greater than 48 hours, it will allow you more flexibility in your rescheduled appointment time options.

It is also important to note that the therapist provides a service with every session and requires payment for each session. The therapist only files claims with third-party payers when requested by the client. Claims will be filed on an out of network basis and may use coding that may not be covered even on an out-of network basis. However, your insurance plan is a contract between you and your insurance vendor. Insurance plans are not a guarantee of coverage and the amount paid is not known until the EOB is received.

Acceptable methods of payment include cash, personal check, or credit card. However if your personal check is returned for insufficient funds the amount of the check, plus any other outstanding checks, plus a $30 NSF check fee, will immediately be charged to your credit card and no further checks will be accepted. By signing below you specifically authorize the credit card payment of any balances due in accordance with this policy.

By signing below you specifically authorize the credit card payment of any balances due in accordance with this policy.

____ ________________

Client Signature Date

____ ________________

Therapist Signature Date

Professional Disclosure Statement

Qualifications: I am currently registered with the Florida State Board of Health as a Licensed Mental Health Counselor. II have successfully passed the Florida State Board Exam for Licensed Mental Health Counselors. I successfully completed the National Counselor Examination administered by the National Board of Certified Counselors. I graduated from the University of North Florida Master's in Counseling Program and have completed the required 3,000 hours of supervised practice and I am qualified to counsel individuals, couples, families, and groups as an independent provider. I am a Licensed Mental Health Counselor Supervisor, trained and qualified to supervise LMHC interns. I have also completed Levels 1-3 training in the Gottman Method Couples Counseling and am currently in their Certification Track. While I have taken training in the Gottman Method Couples Therapy, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. The Gottman Institute or its agents have no responsibility for the services you receive.

Nature of Counseling: My approach to counseling is eclectic and based on the needs of each individual client. We will work together to develop your personal goals and I will offer you more effective ways to deal with your interpersonal problems. I believe that all your behaviors are meaningful and I will help you develop insight into the reasons behind your actions so that you may understand them and move forward to change them. By doing so, we can work to develop any destructive thoughts and behaviors into more productive ones. You may be discouraged in areas of your life such as work, school, or relationships. I will encourage you to take steps to make changes in your life in order to reach your goals successfully in these areas. I believe that you are a creative, goal-oriented individual who can take responsibility for the direction of your own life. Primarily, we will focus on what is happening currently in your life; however, we may explore your past in order for us to gain insight into your current approaches to life.

Counseling Relationship: While we work together, usually we will meet weekly or bi-weekly for approximately 50-minute sessions. Our sessions may be very intimate psychologically, but ours is a professional relationship rather than a social one. You will be best served if our sessions concentrate exclusively on your concerns.

Our in-person contact will be limited to counseling sessions you arrange with me. I will only be in my office location during scheduled times. You may leave messages for me on my voicemail, and I will return your call as soon as possible. If you experience a mental health emergency, obtain crisis services by calling 911 and/or by going to a nearby hospital emergency room.

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Client Rights: Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time; however I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might be harmful.

I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report complaints to the Florida Board of Health at 850-245-4444.

Client Responsibilities: If you have been in counseling or psychotherapy during the past seven years, I may ask you to sign a release so I may communicate with and/or receive copies of records from the professional(s) from whom you received mental health services. While you are in counseling with me you agree not to maintain or establish a professional relationship with another mental health professional unless you first discuss it with me and sign a release that enables me to communicate with the other mental health professional(s).

I also reserve the right to postpone and/or terminate counseling of clients who come to session under the influence of alcohol, drugs, or give the threat of violence in any way. In addition, I reserve the right to terminate counseling of clients who do not comply with the recommendations of their psychiatrist or physician. I may also determine that your needs may be better suited for another professional. In such case, I will provide you with a referral list of other providers in your area.

You agree to inform me at the beginning of each session if: a) You have been hospitalized for any mental health condition; b) you have changed doses, types, or stopped taking any medications; c) You feel you might hurt yourself or anyone else. If you feel this might be the case between sessions you agree to immediately dial 911 or go to the nearest hospital for emergency admission. d) You have a new address, telephone number, or email address. e) Your insurance has changed in any way.

Cancellation & Rescheduling: In the event that you will not be able to keep an appointment, you must notify me at least 48 hours in advance of the appointment time. If I do not receive this notice (all incoming emails and voicemails are time stamped for accuracy), you will be responsible for the full appointment fee for holding the appointment time. Your credit card will be automatically billed for this fee. While I may, at times, call you to remind you of your appointment time, it is ultimately your responsibility to attend each session on time, or call to cancel at least 48 hours prior to your designated appointment. ________ (**initial here**)

Referrals: I recognize that not all conditions presented by clients are appropriate for treatment by me. For this reason, you and/or I may believe that a referral is needed. In that case, I will provide some alternative including programs and/or people who may be available to assist you. A verbal exploration of alternative to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and/or alternatives.

Fees: In return for a fee of $100 per 50-60 minute session, I agree to provide counseling services for you. All fees for each session will be due and must be paid at the beginning of each session. Visa, Mastercard, American Express, cash, and personal checks are acceptable for payment. I currently file in-network claims for Blue Cross Blue Shield, Cigna, and Tricare. All others are filed on an out-of network basis. Any filing of secondary insurance companies will be your responsibility. If any insurance company insures you other than the three listed above you are responsible for full payment at the time of each session. Any reimbursements by your insurance company are due to you by your insurance company.

Records and Confidentiality: All of our communication becomes part of the clinical record. Records will remain my property. Adult client records are disposed of seven years after the file is closed. Minor client records are disposed of seven years after the client's 18th birthday.

Most of our communication is confidential, but the following limitations and exceptions do exist: a) I am using your case records for purposes of professional development, and research, in such cases, to preserve confidentiality, I will identify you by first name only; b) I determine that you are a danger to yourself or someone else; c) you disclosed abuse, neglect, or exploitation of a child, elderly, or disabled person; d) you disclose sexual contact with another mental health professional; e) I am ordered by a court to disclose information; f) you authorize me to release your records with your signature; or g) I am otherwise required by law to disclose information. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first. In the case of marriage or family counseling, I will keep confidential (within limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to the therapeutic progress.

By your signature below, you are indicating that you read and understood this statement and all the information presented in it, and that any questions you had about this statement were answered to your satisfaction.

______________________________ __________________

Client's Name (printed) Date

______________________________ __________________

Client's Signature Date

I have reviewed a copy of the privacy policies of David Tolbert, published at **www.tolbertcounseling.com**, in accordance with HIPAA laws.

______________________________________ ______________________

Printed Name of Patient Date

______________________________________ ______________________

Signature of Patient Date